#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

Pensi	on Benefit Guaranty Corporation				This Form is Open to P Inspection	ublic	
Part I	Annual Report Ide	entification Information			111		
For cale	ndar plan year 2019 or fiscal	l plan year beginning 01/01/2	2019	and ending 12/3	31/2019		
A This	return/report is for:	a multiemployer plan		ployer plan (Filers checking to employer information in accor		ons.)	
		a single-employer plan	a DFE (specify	· -		•	
<b>B</b> This	return/report is:	the first return/report	the final return	n/report			
		an amended return/report	a short plan ye	ear return/report (less than 1	2 months)		
C If the	plan is a collectively-bargair	ned plan, check here	ļģ		▶ 🗍		
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	nsion	the DFVC program		
		special extension (enter description	n)				
Part II	Basic Plan Inform	ation—enter all requested informat	ion				
	ne of plan NFORD EMPLOYEE WE	LFARE TRUST			<b>1b</b> Three-digit plan number (PN) ▶	550	
					<b>1c</b> Effective date of p. 06/29/1987	lan	
2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, apt., suite no. and street, or P.O. Box)  City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  2b Employer Identification Number (EIN)  91–2017261							
	WT ADMINISTRATIVE	2c Plan Sponsor's telephone number 509-372-3323					
	BOX 650, MSIN H3		l SNYDER		2d Business code (see		
	,		N H3-08		instructions) 562000		
RI	CHLAND	WA 99352-0100 RICE	HLAND	WA 99352-0100			
Caution	: A penalty for the late or i	ncomplete filing of this return/repo	ort will be assessed	unless reasonable cause is	s established.		
		penalties set forth in the instructions, as the electronic version of this retur					
	Elsin My lone	on behalf of					
SIGN HERE	Plan Admi.	rist 19 top.	09/18/2020	Elaine Cone			
	Signature of plan admini	strator	Date	Enter name of individual si	gning as plan administrator		
SIGN							
HERE	Signature of employer/pl	an sponsor	Date	Enter name of individual si	gning as employer or plan sp	onsor	
SIGN							
HERE	Signature of DFE		Date	Enter name of individual si	gning as DFE		

	Form 5500 (2019)	Page 2	No.
3a	Plan administrator's name and address 🔀 Same as Plan Sponsor		3b Administrator's EIN
			3c Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed enter the plan sponsor's name, EIN, the plan name and the plan number f		4b EIN
а	Sponsor's name	ioni me iast returni eport.	4d PN
С	Plan Name		
5	Total number of participants at the beginning of the plan year		<b>5</b> 5,519
6	Number of participants as of the end of the plan year unless otherwise sta 6a(2), 6b, 6c, and 6d).	ted (welfare plans complete only lines 6a(1),	
a(	1) Total number of active participants at the beginning of the plan year		. 6a(1) 5,401
a(	2) Total number of active participants at the end of the plan year		. <b>6a(2)</b> 5,445
b	Retired or separated participants receiving benefits		. <b>6b</b> 72
С	Other retired or separated participants entitled to future benefits		<b>6c</b> 0
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d 5,517
е	Deceased participants whose beneficiaries are receiving or are entitled to	receive benefits.	6e
f	Total. Add lines 6d and 6e		. 6f
g	Number of participants with account balances as of the end of the plan year complete this item)		6g
h	Number of participants who terminated employment during the plan year w		6h
7	Enter the total number of employers obligated to contribute to the plan (on		7
	If the plan provides pension benefits, enter the applicable pension feature If the plan provides welfare benefits, enter the applicable welfare feature c 4A 4B 4D 4E 4F 4H 4I 4L 4Q 4U	odes from the List of Plan Characteristics Codes	s in the instructions:
ya	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) i	insurance contracts
	(3) X Trust	(3) X Trust	
40	(4) General assets of the sponsor	(4) X General assets of the sp	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are	attached, and, where indicated, enter the numb	per attached. (See instructions)
а	Pension Schedules	b General Schedules	
	(1) R (Retirement Plan Information)	(1) X H (Financial Inform	•
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)   I (Financial Inform	,
	Purchase Plan Actuarial Information) - signed by the plan	(3) X 8 A (Insurance Inform	
	actuary 	(4) X C (Service Provide	·
	(3) SB (Single-Employer Defined Benefit Plan Actuarial		ng Plan Information)
	Information) - signed by the plan actuary	(6)	action Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
Recei	the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 Form M-1 annual report, enter the pt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)					
Rece	ipt Confirmation Code000087009266					

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Form 5500 (2019)

(Form 5500) Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant	to ERISA section 103(a)(2)	).			n is Open to Public Inspection
For calendar plan year 20	19 or fiscal p	lan year beginning 01/01	./2019	and en	ding 12	2/31/2019	
A Name of plan HANFORD EMPLOYEE WELFARE TRUST				B Three plan	e-digit number (PN	1) 🕨	550
C Plan sponsor's name a	s shown on l	line 2a of Form 5500			-	ation Number (	EIN)
HEWT ADMINIST					2017261		
		erning Insurance Contra A. Individual contracts grouped					
Coverage Information:	ato Correduie	77. marriadar contracto groupot	a ao a amen'i aro ii ana ii	T CON DO TO	portou on a .	Single Concoun	, A.
(a) Name of insurance cal		THE THURSDAYED GOVE	NW A GIGNN GOV	/D3397			
CONNECTICUT G	ENERAL 1	LIFE INSURANCE COMP.				D 17 200	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	Policy or co	(g) To
23-1503749	65498	FLX980014	7,809	. , ,	01/0:	1/2019	12/31/2019
2 Insurance fee and commodescending order of the		mation. Enter the total fees and	total commissions paid. Li	ist in line 3	the agents, I	brokers, and ot	her persons in
		mmissions paid		(b) To	tal amount o	of fees paid	
		55,71	6				0
3 Persons receiving com	missions and	fees. (Complete as many entri	ies as needed to report all	persons).			
	(a) Name	and address of the agent, brok	er, or other person to who	n commissi	ions or fees	were paid	
USI INSURANCE SEI 1350 TREAT BLVD,							
WALNUT CREEK		CA 94597					
(b) Amount of sales an	d base	F	Fees and other commissions paid				
commissions pai	d	(c) Amount	7 N	(d) Purpose			(e) Organization code
	55,716						3
	(a) Namo	and address of the agent, brok	er, or other person to when	n commicci	ions or foos	were paid	
	(a) Ivallie	s and address of the agent, blok	er, or other person to who	II COMMINSSI	IOIIS OI ICES	were paid	
(b) Amount of sales an	d hase	F	ees and other commission	ns paid			
commissions pai	- 1	(c) Amount		(d) Purpose	•		(e) Organization code

Schedule A (Form 5500	) 2019	Page <b>2</b> –	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(4) 142	mo and address of the agent, broke	or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) ruipose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
Commissions paid	```	`,'	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organization code
WEST			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(a) Amount		Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(5)	(-1,	code

P	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts	with each carrier may	he treated as a	unit for nurnoses of
		this report.	idual colluacis i	with cath carrier may	ue irealeu as a	unition purposes of
		rent value of plan's interest under this contract in the general account at year			4	
5 (	Curr	rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
i	a	State the basis of premium rates				
	h	Describers and to accept		Г	Ch	
	b C	Premiums paid to carrier  Premiums due but unpaid at the end of the year		-	6b 6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		F-		
,	u	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
ı	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferrer (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, chec	ck here		
7 (	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
i	а	Type of contract: (1) deposit administration (2) immedia	ite participation	guarantee		
		(3) guaranteed investment (4) other				
		(-, [] 0				
	b	Balance at the end of the previous year			7b	0
(	C	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	<del></del>			
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
		(O)T-1-1 - 44%			70(6)	
	4	(6)Total additions			7c(6) 7d	0
		Total of balance and additions (add lines 7b and 7c(6))			7 u	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		• Control (Specify Bolon)	1.0(.)			
		7				
		(E) Total dad sations			7e(5)	0
		(5) Total deductions				

Schedule A	(Form	-5500)	2010

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a □	fit and contract type (check all applicable boxes)					
a 📋	Health (other than dental or vision) <b>b</b> D	ental	С	Vision		d X Life insurance
e $\square$	Temporary disability (accident and sickness) <b>f</b>	ong-term disabili	ty <b>q</b>	Supplemental un	emplovment	h Prescription drug
ıП		MO contract		PPO contract	<b>,,</b>	I Indemnity contract
m □	Other (specify)	WO COMITACE	K			I Indemnity contract
•••	other (aposity)					
Experi	ience-rated contracts:					
<b>a</b> Pr	remiums: (1) Amount received		9a(1)			
(2	2) Increase (decrease) in amount due but unpaid		9a(2)			
(3	3) Increase (decrease) in unearned premium reserve		9a(3)			
(4	4) Earned ((1) + (2) - (3))				9a(4)	
<b>b</b> B	Benefit charges (1) Claims paid		9b(1)			
(2	2) Increase (decrease) in claim reserves	,	9b(2)			
	3) Incurred claims (add (1) and (2))				9b(3)	
(4	4) Claims charged					
C R	Remainder of premium: (1) Retention charges (on an accr	rual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies	[	9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
(2	2) Dividends or retroactive rate refunds. (These amounts	were paid in	cash, or	credited.)	9c(2)	
	Status of policyholder reserves at end of year: (1) Amount				- 3.7.	
	2) Claim reserves					
,	3) Other reserves					
	) ividends or retroactive rate refunds due. (Do not include					
	experience-rated contracts:			, ,		
а т	otal premiums or subscription charges paid to carrier				10a	2,238,03
	the carrier, service, or other organization incurred any sp					
	etention of the contract or policy, other than reported in Pa					
	fy nature of costs.	<b>,</b>	,			

(Form 5500) Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to				s are required to provide the information o ERISA section 103(a)(2).  This Form is Open to Pul Inspection					
For calendar plan	year 2019 or fis	cal pla	n year beginning 01/01/2	2019	and en	ding 1:	2/31/2	019	
A Name of plan HANFORD E	EMPLOYEE W	ELFA	RE TRUST			B Three-digit plan number (PN)		550	
C Plan sponsor's	name as show	on lir	ne 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Num	ber (E	EIN)
	NISTRATIV					017261			
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.									
1 Coverage Inform	mation:								
(a) Name of insur									
	(c) I	JAIC	(d) Contract or	(e) Approximate no			Policy	or cor	ntract year
(b) EIN	, , ,	de	identification number	'	persons covered at end of policy or contract year		(f) From (g)		<b>(g)</b> To
91-1467158	470	55	6966300	5,135		01/0	/01/2019 12/31/		12/31/2019
2 Insurance fee a descending order			ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3 t	the agents,	brokers, a	nd oth	ner persons in
(a	) Total amount	of com	missions paid		(b) To	tal amount	of fees pai	d	
			59,797						0
3 Persons receiving			ees. (Complete as many entries and address of the agent, broker,			one or food	wara said		
USI INSURANC 23216 NE 126	E SERVICE			, or other person to who	II COMMISSI	ons or lees	were paid		Ÿ
REDMOND		W.	A 98053						
(b) Amount of	sales and base		Fee	es and other commission	ns paid				
commiss		+	(c) Amount	(d) Purpose				(e) Organization code	
	59,	797							3
	(a) N	lame a	and address of the agent, broker,	or other person to who	n commissi	ons or fees	were paid		
(b) Amount of:	sales and hase		Fee	es and other commission	ns paid				
commiss			(c) Amount		(d) Purpose				(e) Organization code

Schedule A (Form 5500	) 2019	Page <b>2 –</b>	Page <b>2 –</b>			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
,						
(b) Amount of sales and base		Fees and other commissions paid	(e)			
commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
(b) Amount of sales and base commissions paid						
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e)			
commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Nai	me and address of the agent, broke	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

1	Part				
		Where individual contracts are provided, the entire group of such individual this report.	ridual contracts with	each carrier may be treated as a unit fo	or purposes of
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
		rent value of plan's interest under this contract in separate accounts at year			
		ntracts With Allocated Funds:			
•	а	State the basis of premium rates			
		•			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year	••••	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with the acc	quisition or 6d	
		retention of the contract or policy, enter amount	•••••		
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guar		
		(3) guaranteed investment (4) other			
		(i) additional information (ii) addition			
	b	Balance at the end of the previous year		7b	0
_	c	Additions: (1) Contributions deposited during the year	1 - 444 1		
		(2) Dividends and credits	- 121		
		(3) Interest credited during the year			
		(4) Transferred from separate account	- 1.5		
		(5) Other (specify below)			
			7.		
		(6)Total additions		7c(6)	0
	ď	Total of balance and additions (add lines 7b and 7c(6)).			0
		Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		<b>)</b>			
		(5) Total deductions		7e(5)	0
	f	Relance at the end of the current year (subtract line 7a/5) from line 7d)	•••••	7f	

Cabadula A	/Earm	EEOO\	2040
Schedule A	(Form	וטטפפ	2019

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Part III	d as a unit. Where control unit for purposes of the unit for purposes o	ontracts cover individual
a ☐ Health (other than dental or vision)  b ☐ Dental  c ☐ Vision  e ☐ Temporary disability (accident and sickness)  f ☐ Long-term disability  g ☐ Suppleme  i ☐ Stop loss (large deductible)  j ☐ HMO contract  k ☐ PPO contr  m ☐ Other (specify)   Experience-rated contracts:  a Premiums: (1) Amount received	9a(4)	h 🗵 Prescription drug I 🗍 Indemnity contract
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Suppleme i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contr m ☐ Other (specify) ▶   9 Experience-rated contracts: a Premiums: (1) Amount received	9a(4)	h 🗵 Prescription drug I 🗍 Indemnity contract
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Suppleme i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contr m ☐ Other (specify) ▶   9 Experience-rated contracts: a Premiums: (1) Amount received	9a(4)	h 🗵 Prescription drug I 🗍 Indemnity contract
i	9a(4)	I Indemnity contract
m ☐ Other (specify) ▶  8 Experience-rated contracts: a Premiums: (1) Amount received	9a(4)	
a Premiums: (1) Amount received       9a(1)         (2) Increase (decrease) in amount due but unpaid       9a(2)         (3) Increase (decrease) in unearned premium reserve       9a(3)         (4) Earned ((1) + (2) - (3))       9b(1)         (2) Increase (decrease) in claim reserves       9b(2)         (3) Incurred claims (add (1) and (2))       9b(2)         (4) Claims charged       9c(1)(A)         (A) Commissions       9c(1)(A)         (B) Administrative service or other fees       9c(1)(B)         (C) Other specific acquisition costs       9c(1)(C)         (D) Other expenses       9c(1)(D)         (E) Taxes       9c(1)(E)         (F) Charges for risks or other contingencies       9c(1)(F)         (G) Other retention charges       9c(1)(G)         (H) Total retention       9c(1)(G)	9b(3)	
(2) Increase (decrease) in amount due but unpaid       9a(2)         (3) Increase (decrease) in unearned premium reserve       9a(3)         (4) Earned ((1) + (2) - (3))       9b(1)         (2) Increase (decrease) in claim paid       9b(1)         (2) Increase (decrease) in claim reserves       9b(2)         (3) Incurred claims (add (1) and (2))       9b(2)         (4) Claims charged       9c(1)(A)         (A) Commissions       9c(1)(A)         (B) Administrative service or other fees       9c(1)(B)         (C) Other specific acquisition costs       9c(1)(C)         (D) Other expenses       9c(1)(D)         (E) Taxes       9c(1)(E)         (F) Charges for risks or other contingencies       9c(1)(F)         (G) Other retention charges       9c(1)(G)         (H) Total retention       9c(1)(G)	9b(3)	
(3) Increase (decrease) in unearned premium reserve 9a(3)  (4) Earned ((1) + (2) - (3))	9b(3)	
(4) Earned ((1) + (2) - (3)).  b Benefit charges (1) Claims paid	9b(3)	
b Benefit charges (1) Claims paid	9b(3)	
(2) Increase (decrease) in claim reserves		0
(3) Incurred claims (add (1) and (2))  (4) Claims charged  C Remainder of premium: (1) Retention charges (on an accrual basis) —  (A) Commissions 9c(1)(A)  (B) Administrative service or other fees 9c(1)(B)  (C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)		0
(4) Claims charged  Remainder of premium: (1) Retention charges (on an accrual basis)  (A) Commissions 9c(1)(A)  (B) Administrative service or other fees 9c(1)(B)  (C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)  (H) Total retention		0
C Remainder of premium: (1) Retention charges (on an accrual basis) —  (A) Commissions ————————————————————————————————————	9b(4)	
(A) Commissions       9c(1)(A)         (B) Administrative service or other fees       9c(1)(B)         (C) Other specific acquisition costs       9c(1)(C)         (D) Other expenses       9c(1)(D)         (E) Taxes       9c(1)(E)         (F) Charges for risks or other contingencies       9c(1)(F)         (G) Other retention charges       9c(1)(G)         (H) Total retention		
(B) Administrative service or other fees 9c(1)(B)  (C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)  (H) Total retention		
(C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)  (H) Total retention		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		
(H) Total retention		
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	9c(1)(H)	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
(2) Claim reserves		
(3) Other reserves.		
Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	1.7	
10 Nonexperience-rated contracts:		
Total premiums or subscription charges paid to carrier	10a	36,170,327
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisi		1
retention of the contract or policy, other than reported in Part I, line 2 above, report amount		

Part IV	Provision of Information			
11 Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the answer to line 11 is "Yes," specify the information not provided.				

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

OMB No. 1210-0110

					100		
Pension Benefit Guaranty Con	poration		s are required to provide to ERISA section 103(a)(2		ion	This Fo	orm is Open to Public Inspection
For calendar plan year 201	9 or fiscal pl	an year beginning 01/01/	/2019	and en	ding 12,	/31/201	9
A Name of plan HANFORD EMPLOY	EE WELF	ARE TRUST		B Three	e-digit number (PN)	•	550
C Plan sponsor's name as	shown on li	ine 2a of Form 5500		<b>D</b> Emplo	yer Identificat	ion Number	(EIN)
HEWT ADMINISTR	ATIVE C	OMMITTEE		91-2	017261		
Part I Informati on a separa	on Conce te Schedule	erning Insurance Contract  A. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and I	and Com	nmissions orted on a si	Provide info	ormation for each contract ule A.
1 Coverage Information:							
(a) Name of insurance carr		IFE INSURANCE COMPA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year
(=) =	code	identification number	policy or contract		(f) F	rom	(g) To
23-1503749	65498	OK980022	4,987		01/01	/2019	12/31/2019
2 Insurance fee and commodescending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3 t	he agents, br	okers, and	other persons in
(a) Total ar	mount of con	nmissions paid		( <b>b</b> ) To	tal amount of	fees paid	
		9,491					
3 Persons receiving comm	nissions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ons or fees w	ere paid	
USI INSURANCE SER 1350 TREAT BLVD,							
WALNUT CREEK	(	CA 94597					
(b) Amount of sales and	d base	Fe	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	9,491						3
	(a) Name	and address of the agent, broke	r, or other person to who	m commissi	ons or fees w	ere naid	
	(d) Name	and address of the agent, broke	i, or other person to who	111 00111111331	0113 01 1003 11	crc paid	
(b) Amount of sales and			ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500) 2019		Page <b>2</b> —	
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	no and address of the agent br	oker, or other person to whom commissions or fees were paid	
(a) Ivai	ne and address of the agent, bit	oner, or other person to whom commissions or rees were palu	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

D	art II Investment and Annuity Contract Information			
"	Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier ma	ay be treated as a unit	for purposes of
Ļ	this report.			
	Current value of plan's interest under this contract in the general account at year			
	Current value of plan's interest under this contract in separate accounts at year	end	5	
	Contracts With Allocated Funds:			
	a State the basis of premium rates			
	<b>b</b> Premiums paid to carrier		6b	
	C Premiums due but unpaid at the end of the year			
	d If the carrier, service, or other organization incurred any specific costs in co			
	retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
(	e Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
	f If contract purchased, in whole or in part, to distribute benefits from a terminal	nating plan, check here		
7 (	Contracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
	<b>a</b> Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	Balance at the end of the previous year		7b	0
(	C Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	•			
	(6)Total additions			0
	d Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:  (1) Dishussed from fined to pay happfite as a washess appointed during uses.	7e(1)		
	(1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier			
	(3) Transferred to separate account.	7e(2)		
	(4) Other (specify below)	- 4.44		
	•	1.1.1		
	•			
	(F) Total daductions		70(5)	
	(5) Total deductions  f Balance at the end of the current year (subtract line 7e(5) from line 7d)		7e(5)	0

P	ac	ıе	4

Part III  Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the same employer(s) or members the information may be combined for reporting purposes if such contracts are experience-rated as a unit for employees, the entire group of such individual contracts with each carrier may be treated as a unit for	nit. Where co	ontracts cover individual
8 Benefit and contract type (check all applicable boxes)		
a  Health (other than dental or vision)  b  Dental  c  Vision		d X Life insurance
e Temporary disability (accident and sickness) f Long-term disability g Supplemental une	molovment	h Prescription drug
i Stop loss (large deductible) j HMO contract k PPO contract	pio yo	I Indemnity contract
		I Indemnity contract
m ☐ Other (specify) ▶		
9 Experience-rated contracts:		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))	9a(4)	0
b Benefit charges (1) Claims paid		
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))		0
(4) Claims charged	9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)		4
(A) Commissions 9c(1)(A)		-
(B) Administrative service or other fees 9c(1)(B) (C) Other specific acquisition costs 9c(1)(C)		-
0 (4)(m)		-
(D) Other expenses		-
(F) Charges for risks or other contingencies		-
(G) Other retention charges		
(H) Total retention	9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	1	
(2) Claim reserves		
(3) Other reserves	- 2	•
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		
10 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier	10a	94,908
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		
retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	
Specify nature of costs.		

Part IV	Provision of Information			
11 Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the answer to line 11 is "Yes," specify the information not provided.				

(Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to	ERISA section 103(a)(2)				Inspection
For calendar plan year 20	19 or fiscal p	lan year beginning 01/01/	/2019	and end	ing 1	2/31/2019	
A Name of plan HANFORD EMPLOY	YEE WELF	FARE TRUST		B Three-digit plan number (PN) ▶ 550			
C Plan sponsor's name a	s shown on	line 2a of Form 5500		D Employ	er Identifi	cation Number (	EIN)
				91-20	017261		
Part I Informat		:OMMITTEE erning Insurance Contra	ct Coverage, Fees.			1S Provide infor	mation for each contract
		A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
CONNECTICUT G	ENERAL 1	LIFE INSURANCE COMPA	NY, A CIGNA COM	IPANY			
	(c) NAIC	(d) Contract or	(e) Approximate nu	-		Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
23-1503749	65498	OK980033	3,594		01/0	1/2019	12/31/2019
2 Insurance fee and come descending order of the		mation. Enter the total fees and to	otal commissions paid. Li	st in line 3 th	e agents,	brokers, and ot	her persons in
		mmissions paid		(b) Tota	al amount	of fees paid	
		38,515					0
3 Persons receiving com	missions and	d fees. (Complete as many entrie	es as needed to report all	persons).			
		e and address of the agent, broke	r, or other person to whor	n commissio	ns or fees	were paid	
USI INSURANCE SEI 1350 TREAT BLVD,							
WALNUT CREEK		CA 94597					
(b) Amount of sales an	d base	Fe	ees and other commission	ns paid			
commissions pai	d	(c) Amount (d)		(d) Purpose			(e) Organization code
	38,515						3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commissio	ns or fees	were paid	
(b) Amount of sales an	d hase	Fe	ees and other commission	s paid			
commissions pai		(c) Amount		d) Purpose			(e) Organization code

Schedule A (Form 5500	) 2019	Page <b>2</b> —	
(a) No	ma and address of the areast broke	er, or other person to whom commissions or fees were paid	
(a) Na	me and address of the agent, broke	ir, or other person to whom commissions or rees were paid	
		Food and other commissions while	(0)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
(a) Na	me and address of the arient, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
(a) Naı	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		,	
0.3 A		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

-	at II Investment and Annuity Contract Information			
Pa	rt II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	vidual contracts with each carri		or purposes of
	urrent value of plan's interest under this contract in the general account at year			
<b>5</b> C	urrent value of plan's interest under this contract in separate accounts at year o	end	5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			
	Specify nature of costs			
е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	ed annuity		
f	If contract purchased, in whole or in part, to distribute benefits from a terminal	nating plan, check here	П	
<b>7</b> Co	ontracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts	)	
а		ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	(5) Gualanteed investment (4) Gualanteed			
b	Balance at the end of the previous year		7b	0
c				
·	(2) Dividends and credits	- 141		
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	- 1-1		
	•			
	(6)Total additions		7c(6)	0
c	Total of balance and additions (add lines 7b and 7c(6)).			0
	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	-	
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	1 - 7.0	-	
	•			
	•			
	(5) Total deductions	-		0
_	(5) Total deductions	•••••	7e(5)	0

<sup>2</sup> ad	е	4
ay	C	7

	If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	ng purposes if such cont	racts are exp	perience-rated as a uni	t. Where cor	ntracts cover individual
<b>8</b> B	enefit and contract type (check all applicable boxes)					
a	Health (other than dental or vision)	<b>b</b> Dental	c	Vision		d X Life insurance
e	Temporary disability (accident and sickness)	f   Long-term disabili	ty <b>g</b>	Supplemental unem	plovment	h Prescription drug
i	Stop loss (large deductible)	i  HMO contract	v St	=	p,	I  Indemnity contract
r		, L · ······ ooi.iaaai	[	] , , o oonaada		
	The Other (Specify)					
9 E	perience-rated contracts:					
	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpaid.		0.00			
	(3) Increase (decrease) in unearned premium rese	erve				
	(4) Earned ((1) + (2) - (3))				9a(4)	0
- 1	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)		7.	
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	
•	Remainder of premium: (1) Retention charges (on	an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees					
	(C) Other specific acquisition costs					
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These a	amounts were 🗌 paid in	cash, or	credited.)	9c(2)	
(	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	r retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
€	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line <b>9c(2</b> )	).)	9e	
10	Nonexperience-rated contracts:					
a	Total premiums or subscription charges paid to ca	rrier		***************************************	10a	385,156
k	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor				10b	
S	pecify nature of costs.	teo in Fait I, lille 2 abovi	e, report and	Juni	100	

Part IV	Provision of Information			
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the ar	swer to line 11 is "Yes," specify the information not provided.			

(Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant t	to ERISA section 103(a)(2	).	This ro	Inspection
For calendar plan year 20	19 or fiscal p	lan year beginning 01/01	/2019	and ending	12/31/201	9
A Name of plan HANFORD EMPLO	YEE WELF	PARE TRUST		B Three-dig plan nun	git nber (PN)	550
C Plan sponsor's name a	ıs shown on	line 2a of Form 5500		<b>D</b> Employer	Identification Number	(EIN)
HEWT ADMINIST	RATIVE C	COMMITTEE		91-201	7261	
Part I Informat	ion Conc	erning Insurance Contra A. Individual contracts grouped				
1 Coverage Information:		V 1				
(a) Name of insurance ca	rrier					
CONNECTICUT G	ENERAL I	LIFE INSURANCE COMPA	ANY, A CIGNA COM	IPANY		
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate no		Policy or o	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
23-1503749	65498	LK960119	5,016		01/01/2019	12/31/2019
2 Insurance fee and com- descending order of the		mation. Enter the total fees and	total commissions paid. L	ist in line 3 the a	agents, brokers, and o	other persons in
(a) Total a	amount of co	mmissions paid		(b) Total a	amount of fees paid	
		61,738	8			
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).		
		and address of the agent, broke	er, or other person to who	n commissions	or fees were paid	
JSI INSURANCE SEI 1350 TREAT BLVD,						
VALNUT CREEK		CA 94597				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid		
commissions pai	d	(c) Amount		(d) Purpose		(e) Organization code
	61,738					3
	(a) Name	and address of the agent, broke	er, or other person to who	n commissions	or fees were paid	
(b) Amount of sales ar	id base	F	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code

Schedule A (Form 5500	) 2019	Page <b>2</b> —					
(a) Na	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	1				
Fees and other commissions paid							
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organizatio				
(a) Na	me and address of the agent, brol	ker, or other person to whom commissions or fees were paid					
(h) Amount of color and have		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organizatio code				
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were paid					
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organizatio code				
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organizatio code				
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organizatio code				

	1			
Pai	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	ridual contracts with each carrier m	nay be treated as a unit	for purposes of
<b>4</b> Cu	irrent value of plan's interest under this contract in the general account at year	end	4	
<b>5</b> Cu	Current value of plan's interest under this contract in separate accounts at year end		5	
<b>6</b> Cc	ontracts With Allocated Funds:		1	
а	State the basis of premium rates •			
b	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year	•••••	6с	
d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre (3) ☐ other (specify) ▶	d annuity		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
<b>7</b> Co	ntracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) mmedia (3) guaranteed investment (4) other	ate participation guarantee		
b	Balance at the end of the previous year		7b	0
С	Additions: (1) Contributions deposited during the year	7.2		
	(2) Dividends and credits	3-6-1		
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).			0
е	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	. 7e(2)		
	(3) Transferred to separate account	. 7e(3)		
	(4) Other (specify below)	- (4)		
	•			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			0

Pag	e	4

8 Benefit and contract type (check all applicable boxes) a	Par	rt III	Welfare Benefit Contract Inform. If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of the ting purposes if such cont	racts are exp	erience-rated as a un	it. Where co	ontracts cover individual
e ∑ Temporary disability (accident and sickness) f	<b>8</b> B	enefit a	nd contract type (check all applicable boxes)					
I stop loss (large deductible)  J HMO contract  M Other (specify)  9 Experience-rated contracts:  a Premiums: (1) Amount received	а	. ∏ не	ealth (other than dental or vision)	<b>b</b> Dental	c	Vision		d Life insurance
I stop loss (large deductible)  J HMO contract  M Other (specify)  9 Experience-rated contracts:  a Premiums: (1) Amount received	е	X Te	emporary disability (accident and sickness)	f Long-term disabili	tv <b>a</b> [	Supplemental uner	plovment	h Prescription drug
m ☐ Other (specify) ▶  9 Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. 9a(2) (3) Increase (decrease) in unearned premium reserve. 9a(3) (4) Earned (1) + (2) - (3)). 9a(4)  b Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. 9b(2) (3) Incurred claims (add (1) and (2)). (4) Claims charged. (5) Increase (decrease) in claim reserves. (6) C Remainder of premium: (1) Retention charges (on an accrual basis) — (6) C Remainder of premium: (1) Retention charges (on an accrual basis) — (7) C Other specific acquisition costs. (8) Administrative service or other fees. (9c(1)(A) (9c(1)(A) (1) Other expenses. (2) Other retention charges. (3) Other retention charges. (4) Claims charged (1) Claims charge	i	$\exists$	•			<b></b>		
9 Experience-rated contracts:  a Premiums: (1) Amount received				, I mile contract	ν.	] 110 contract		I I indemnity contract
a Premiums: (1) Amount received	"	<u> </u>	ther (specify)					
(2) Increase (decrease) in amount due but unpaid	9 Ex	perienc	ce-rated contracts:					
(2) Increase (decrease) in amount due but unpaid	а	Prem	iums: (1) Amount received		9a(1)			
(3) Increase (decrease) in unearned premium reserve 9a(3)  (4) Earned ((1) + (2) - (3))		(2) ir	ncrease (decrease) in amount due but unpaid	j				
b Benefit charges (1) Claims paid		(3) Ir	ncrease (decrease) in unearned premium res	serve				
(2) Increase (decrease) in claim reserves		(4) E	Earned ((1) + (2) - (3))				. 9a(4)	(
(3) Incurred claims (add (1) and (2))	b	) Ben	efit charges (1) Claims paid		9b(1)			
(4) Claims charged		(2) Ir	ncrease (decrease) in claim reserves		9b(2)		<i>10</i>	
C Remainder of premium: (1) Retention charges (on an accrual basis) —  (A) Commissions		(3) ir	ncurred claims (add (1) and (2))				. 9b(3)	
(A) Commissions		(4) C	Claims charged			•••••	9b(4)	
(B) Administrative service or other fees	C	Rem	nainder of premium: (1) Retention charges (o	n an accrual basis)				
(C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)  (H) Total retention 9c(1)(G)  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a 3,060,3		(	(A) Commissions		9c(1)(A)			
(D) Other expenses								
(E) Taxes								
(F) Charges for risks or other contingencies								
(G) Other retention charges								
(H) Total retention								
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)							0-/4//11	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  E Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a 3,060,3  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		,	· ·					0
(2) Claim reserves	الم	_		_	_			
(3) Other reserves	a		· · · · · · · · · · · · · · · · · · ·	•				
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier								
10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier	•							
a Total premiums or subscription charges paid to carrier				ot include amount entered	in line 9c(2)	.)	. 9е	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or				orrior			10-	2 060 256
							iva	3,000,350
	D						10b	
Specify nature of costs.	Sp				-,			

Pa	rt IV	Provision of Information			
_11	Did the i	surance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12	If the an	wer to line 11 is "Yes," specify the information not provided.	77		

(Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2019

This Form is Open to Public

		pursuant	to ERISA section 103(a)(2	).		1	Inspection
For calendar plan year 20	19 or fiscal p	olan year beginning 01/01	./2019	and en	ding 1	2/31/2019	
A Name of plan HANFORD EMPLOY	YEE WELF	FARE TRUST		B Three	e-digit number (F	PN) ▶	550`
C Plan sponsor's name a	s shown on	line 2a of Form 5500		<b>D</b> Emplo	yer Identifi	cation Number (	EIN)
HEWT ADMINIST	RATIVE C	COMMITTEE		91-2	017261		
Part I Informat on a separa	ion Conc ate Schedule	erning Insurance Contra A. Individual contracts groupe	act Coverage, Fees, d as a unit in Parts II and I	and Con	nmissior orted on a	<b>1S</b> Provide infor single Schedul	mation for each contract e A.
1 Coverage Information:							
(a) Name of insurance car	rrier						
WILLAMETTE DE	NTAL, I	NC.					
a > ====	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		<b>(f)</b>	From	<b>(g)</b> To
91-1702099	47050	Z148	1,509		01/0	1/2019	12/31/2019
2 Insurance fee and common descending order of the		mation. Enter the total fees and	total commissions paid. L	ist in line 3 t	the agents,	brokers, and of	ther persons in
(a) Total a	mount of co	mmissions paid		(b) To	tal amount	of fees paid	
		63,52	7				
3 Persons receiving comr	nissions and	d fees. (Complete as many entri	ies as needed to report all	persons).			
	-775	and address of the agent, brok			ons or fees	were paid	
JSI INSURANCE SEF 1350 TREAT BLVD,							
VALNUT CREEK		CA 94597					
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
commissions paid	d	(c) Amount	<u> </u>	(d) Purpose			(e) Organization code
	63,527						3
		and address of the agent, brok	ar or other bereen to who	m commicci	one or food	wore said	II.
	(a) Ivaille	e and address of the agent, blok	er, or other person to who	II COIIIIIISSI	ons or lees	were paid	
(b) Amount of sales and		75.0	ees and other commission	ns paid			
commissions paid	1	(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500	2019	Page <b>2</b> —	
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were pa	id
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base	4 ) 4	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
(a) Nan	ne and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nan	ne and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contra	acts with each carrier may	be treated	as a unit for nurposes of
_		this report.				
		rent value of plan's interest under this contract in the general account at year			4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		ntracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	c	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
		retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
		_				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(a) Displayment (4) District (				
	b	Balance at the end of the previous year		1	7b	0
	C	Additions: (1) Contributions deposited during the year			710	
	-	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	1 1			
		(5) Other (specify below)	1 1 1			
		<b>•</b>				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	0
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	0

12 If the answer to line 11 is "Yes," specify the information not provided.

Part III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor	group of employees of the	tracts are	expe	rience-rated as a unit	Where co	ntracts co	ver individual
9 Danset	employees, the entire group of such individ		carrier may	be t	reated as a unit for pu	rposes or ti	nis report.	
_	and contract type (check all applicable boxes	_		. $\Box$				
a∐ı	Health (other than dental or vision)	<b>b</b> X Dental	1	c∐	Vision		d Life	insurance
е 📙 -	Temporary disability (accident and sickness)	f Long-term disabil	lity 9	g 🗌	Supplemental unemp	loyment	h Pre	scription drug
i 🛮 🤅	Stop loss (large deductible)	j HMO contract		k 🗌	PPO contract		I Inde	emnity contract
m 🗍	Other (specify)	_		_				
9 Experie	nce-rated contracts:						T	
<b>a</b> Pre	miums: (1) Amount received		. 9a(1)					
(2)	Increase (decrease) in amount due but unpai	d	-	_			1	
(3)	Increase (decrease) in unearned premium re-	serve	- 1-1	_				
(4)	Earned ((1) + (2) - (3))	•••••				9a(4)		0
<b>b</b> Be	enefit charges (1) Claims paid		9b(1)		11			
(2)	Increase (decrease) in claim reserves		9b(2)					
(3)	Incurred claims (add (1) and (2))					9b(3)		0
(4)	Claims charged				[	9b(4)		
C Re	emainder of premium: (1) Retention charges (	n an accrual basis)						
	(A) Commissions		9c(1)(A	()				
	(B) Administrative service or other fees							
	(C) Other specific acquisition costs			_				
	(D) Other expenses							
	(E) Taxes							
	(F) Charges for risks or other contingencies.							
	(G) Other retention charges		9c(1)(G	5)		. 01.701.10		
	(H) Total retention			_	1	9c(1)(H)		0
(2)	Dividends or retroactive rate refunds. (These	amounts were 📗 paid in	n cash, or	CI	redited.)	9c(2)		
<b>d</b> Sta	atus of policyholder reserves at end of year: (1	) Amount held to provide	benefits a	fter r	etirement	9d(1)		
(2)	Claim reserves					9d(2)		
	Other reserves				+	9d(3)		
	vidends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 90	<b>(2)</b> .)		9e		
	perience-rated contracts:				-			
<b>a</b> To	tal premiums or subscription charges paid to o	arrier				10a		2,117,560
ret	he carrier, service, or other organization incurrention of the contract or policy, other than represented of costs.					10b		
Part IV	Provision of Information				pinns.			
11 Did the	e insurance company fail to provide any inform	ation necessary to comp	lete Sched	lule A	١? ا	Yes [	No	

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Tersion Benefit Guaranty Gorporation		pursuant to	ERISA section 103(a)(2)				rm is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019							
A Name of plan HANFORD EMPLOYEE WE	LFARE TI	RUST		B Thre plan	e-digit number (PN)	<b>•</b>	550
C Plan sponsor's name as shown	on line 2a of	Form 5500		<b>D</b> Emplo	yer Identificatio	n Number	(EIN)
HEWT ADMINISTRATIVE	COMMIT	ree .		91-2	2017261		
			ct Coverage, Fees, as a unit in Parts II and II				rmation for each contract le A.
1 Coverage Information:							
(a) Name of insurance carrier  CONNECTICUT GENERAL	LIFE I	NSURANCE COMPA	NY, A CIGNA COM	PANY			
(A) N	110	(0.0.1.1.1	(e) Approximate nu	mber of		Policy or c	ontract year
(b) EIN (c) No code		(d) Contract or identification number	persons covered at policy or contract	t end of	(f) Fro		(g) To
23-1503749 6549	98	ABL980009	4,987		01/01/	2019	12/31/2019
2 Insurance fee and commission in descending order of the amount p		nter the total fees and to	tal commissions paid. Li	st in line 3	the agents, brok	cers, and o	ther persons in
(a) Total amount of	commission	s paid		(b) To	otal amount of fe	es paid	
		194					
3 Persons receiving commissions	and fees. (C	omplete as many entries	s as needed to report all p	persons).			
(a) Na USI INSURANCE SERVICES 1350 TREAT BLVD, SUITE	NA	ress of the agent, broker	, or other person to whom	n commissi	ions or fees wer	e paid	
WALNUT CREEK	CA	94597					
(h) Amount of calca and hace		Fe	es and other commission	s paid			
(b) Amount of sales and base commissions paid		(c) Amount		d) Purpose	•		(e) Organization code
1.9	94						3
(a) Na	me and addı	ress of the agent, broker	, or other person to whon	n commissi	ions or fees wer	e paid	
(b) Amount of sales and hase		Fe	es and other commission	s paid			
(b) Amount of sales and base commissions paid		(c) Amount		s paid d) Purpose	)		(e) Organization code

Schedule A (Form 5500	) 2019	Page <b>2</b> —	
(a) Na	ime and address of the agent, bro	ker, or other person to whom commissions or fees were paid	
<del></del>		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, brol	ker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the adent brok	ker, or other person to whom commissions or fees were paid	
10/10	mo and address of the agont, sion	to the person to whom dominiosions of 1000 from paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contrac	te with each carrier may b	e treated o	e a unit for purposes of
		this report.	iuuai condac	io with each camer may b	e ucaled a	s a unit for purposes of
4	Cun	rent value of plan's interest under this contract in the general account at year	end		4	
5	Curr	rent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in coretention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	_ ` _ ` _	ate participation			
	-	(3) guaranteed investment (4) other		•		
		(3)   guaranteed investment (4)   other P				
	b	Balance at the end of the previous year		Г	7b	0
_	C	Additions: (1) Contributions deposited during the year			10	
	•	(2) Dividends and credits	- (0)		-	
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)				
		<b>)</b>				
		(0)7-4-1-4-29			70/6\	0
	٨	(6)Total additions  Total of balance and additions (add lines 7b and 7c(6)).			7c(6) 7d	0
					/u	
		Deductions:	7e(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		-	
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	16(4)			
		<b>P</b>				
		(5) Total deductions			7e(5)	0
	£	Palance at the and of the autropt year (subtract line 7a/5) from line 7d)			7f	0

Pa	n	6	4

F	art	Ш	Welfare Benefit Contract Information from than one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ing pi	of employees of the urposes if such cont	racts are ex	хре	erience-rated as a uni	it. Where co	ntraci	ts cover individual
8	Ber	nefit aı	nd contract type (check all applicable boxes)								
	а	∏ Не	ealth (other than dental or vision)	bΓ	Dental	C		Vision		d X	Life insurance
	е	∏ Пте	emporary disability (accident and sickness)	fΓ	Long-term disabilit	ty <b>g</b>	П	Supplemental unem	plovment	hΠ	Prescription drug
	i	=	op loss (large deductible)	iF	HMO contract	, s k	=	PPO contract			Indemnity contract
		닏		י ר	TIMO CONTRACT	K	Ш	FFO contract		• 🗀	indennity contract
	m		her (specify)								
9	Exp	erienc	ce-rated contracts:				_		-	T	
			iums: (1) Amount received			9a(1)	1				
		(2) Ir	ncrease (decrease) in amount due but unpaid				7				
		(3) In	ncrease (decrease) in unearned premium res	erve .		9a(3)	T				
		(4) E	arned ((1) + (2) - (3))						9a(4)		0
	b		efit charges (1) Claims paid				1				
		(2) In	ncrease (decrease) in claim reserves			9b(2)	1				
		(3) In	ncurred claims (add (1) and (2))						9b(3)		0
		٠,	laims charged				••••		9b(4)		
	C		nainder of premium: (1) Retention charges (or				_			4	
		•	A) Commissions		,	9c(1)(A)	_			4	
		•	B) Administrative service or other fees		1	9c(1)(B)				4	
		•	C) Other specific acquisition costs		1	9c(1)(C) 9c(1)(D)	_			4	
		•	D) Other expenses		ł	9c(1)(E)	+			-	
			E) TaxesF) Charges for risks or other contingencies				+			+	
			G) Other retention charges			9c(1)(G)	+			1	
			H) Total retention				_		9c(1)(H)	+	0
		•	Dividends or retroactive rate refunds. (These								
	d		us of policyholder reserves at end of year: (1)		ш .	<u> </u>		· ·		+-	
	~		Claim reserves		•				9d(2)	+	
			Other reserves						9d(3)		
	е	` '	lends or retroactive rate refunds due. (Do no								
10			erience-rated contracts:				,	,			
	а	Total	I premiums or subscription charges paid to ca	arrier					10a		1,939
	b		carrier, service, or other organization incurre		, ,			•	401		
	Spe		ntion of the contract or policy, other than repo ature of costs.	rted i	n Part I, line 2 above	e, report an	noı	unt	10b	_	
	Spe	ony ne	adic or costs.								

Part IV	Provision of Information				
11 Did the	insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No	
12 If the ar	swer to line 11 is "Yes," specify the information not provided.				

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

# **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation			es are required to provide to ERISA section 103(a)(2		on	This Form is Open to Public Inspection		
For calendar plan ye	ear 2019 or fiscal p	lan year beginning 01/01	/2019	and end	ding 12	/31/201	9	
A Name of plan HANFORD EM	PLOYEE WELF	FARE TRUST		B Three plan	e-digit number (PN)	<b>•</b>	550	
C Plan sponsor's n	ame as shown on	line 2a of Form 5500		D Employ	er Identifica	tion Numbe	r (EIN)	
	ISTRATIVE (				017261		,	
Part i Info	rmation Conc	erning Insurance Contra						
1 Coverage informa								
(a) Name of insuran								
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or	contract year	
(b) EIN (c) NAIC (d) Contract or code identification number			persons covered a policy or contract		<b>(f)</b> F	rom	<b>(g)</b> To	
91-1467158 47055 6813500			5,771		01/01	/2019	12/31/2019	
2 Insurance fee and descending order		mation. Enter the total fees and i.	total commissions paid. L	ist in line 3 t	he agents, bi	rokers, and	other persons in	
(a)	Total amount of co	mmissions paid		(b) Tot	al amount of	fees paid		
		76,77	0				(	
3 Persons receiving	g commissions and	i fees. (Complete as many entri	ies as needed to report all	persons).				
USI INSURANCE 23216 NE 126T	SERVICES N	and address of the agent, brok IA	er, or other person to who	m commissio	ons or fees w	ere paid		
REDMOND		WA 98053						
(b) Amount of sa			ees and other commissio	ne li como				
commissio	ns paid	(c) Amount		(d) Purpose			(e) Organization code	
	76,770						3	
	(a) Name	and address of the agent, brok	er, or other person to who	m commission	ons or fees w	ere paid		
(b) Amount of sa	les and base	F	ees and other commissio	ns paid				
commission		(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500	) 2019	Page <b>2</b> —	
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were pai	d
	1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, br	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pair	1
(6) / 10	ino ana address of the agony bit	stor, at sailer parson to whom commissions or 1000 were part	•
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	ı
(L) A		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Pa	rt II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indi-	vidual contracts with each carrier ma	ay be treated as a u	ınit for purposes of
4.0	this report.		1 4 1	
	urrent value of plan's interest under this contract in the general account at year			
	urrent value of plan's interest under this contract in separate accounts at year	ena	5	
	ontracts With Allocated Funds:  State the basis of premium rates			
а	State the basis of premium rates F			
b	Premiums paid to carrier		6b	
c	Premiums due but unpaid at the end of the year			
d				
	retention of the contract or policy, enter amount.	·	6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
1	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma			
a		ate participation guarantee		
•	7 7 7 7 8 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8			
	(3) guaranteed investment (4) other			
<b>L</b>	D. I I		74	
b			7b	0
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits(3) Interest credited during the year			
	(4) Transferred from separate account.	- 7.0		
	(5) Other (specify below)			
	(o) Outer (speedify below)	10(0)		
	,			
	(C)Tatal additions		70(6)	
c	(6)Total additions			0
6			. ru	
•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	27-07-1		
	)			
	•			
_	(5) Total deductions			0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		. 7f	0

Р	۵	n	Р	4

	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of the ting purposes if such con- lual contracts with each of	tracts are exp	erience-rated as a ur	it. Where co	ontracts cover individual
8	Benefit and contract type (check all applicable boxes	_	_			
	a   ☑ Health (other than dental or vision)	<b>b</b> Dental	C	Vision		d Life insurance
	e Temporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b> [	Supplemental unen	ployment	h 🛛 Prescription drug
	i Stop loss (large deductible)	j 🔲 HMO contract	k[	PPO contract		I Indemnity contract
	m ☐ Other (specify) ▶					
9	Experience-rated contracts:					
	a Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	0
	<b>b</b> Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged			•••••	9b(4)	
	<b>c</b> Remainder of premium: (1) Retention charges (c	n an accrual basis)				
	(A) Commissions		9c(1)(A)			_
	(B) Administrative service or other fees		0 (4)(0)			_
	(C) Other specific acquisition costs					
	(D) Other expenses		0 (4)(5)			
	(E) Taxes		A (41/90)			
	(F) Charges for risks or other contingencies.		0. (4)(0)			-
	(G) Other retention charges				1 - 2000	
	(H) Total retention	_	_		1 1 1 1	0
	(2) Dividends or retroactive rate refunds. (These	amounts were 📋 paid in	n cash, or	credited.)	- 9c(2)	
	<b>d</b> Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)	
	(2) Claim reserves				1.7	
	(3) Other reserves				1	
- 10	e Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2)	.)	9e	
10	Nonexperience-rated contracts:					
	a Total premiums or subscription charges paid to o	arrier			10a	41,952,304
	b If the carrier, service, or other organization incur retention of the contract or policy, other than rep Specify nature of costs.				10b	

Pa	art IV	Provision of Information			
11	Did the i	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	⊠ No	
12	If the an	swer to line 11 is "Yes," specify the information not provided.			

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

# **Service Provider Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2019

This Form is Open to Public Inspection.

	islon benefit dualanty corporation				
For ca	endar plan year 2019 or fiscal plan year beginning 01/01/2019		and ending 12	/31/2	2019
A Na	f plan	В	Three-digit		
HANFORD EMPLOYEE WELFARE TRUST			plan number (PN)	•	550
			promit transfer (1 11)		330
C Pla	Plan sponsor's name as shown on line 2a of Form 5500		D Employer Identification Number (EIN)		
			, ,	,	,
HE	T ADMINISTRATIVE COMMITTEE		91-2017261		
Par	Service Provider Information (see instructions)				
or n plar	must complete this Part, in accordance with the instructions, to report the information re ore in total compensation (i.e., money or anything else of monetary value) in connectior during the plan year. If a person received <b>only</b> eligible indirect compensation for which er line 1 but are not required to include that person when completing the remainder of	with the	services rendered to the polan received the required	plan or th	he person's position with the
1 Inf	ormation on Persons Receiving Only Eligible Indirect Compensat	on			
	k "Yes" or "No" to indicate whether you are excluding a person from the remainder of the		et bacques they received	only olig	iblo
	ect compensation for which the plan received the required disclosures (see instructions		•		
iliai	ct compensation for which the plan received the required disclosures (see instructions	ioi u	enniuons and conditions)		∐ Yes ⊠ No
	u answered line 1a "Yes," enter the name and EIN or address of each person providing yed only eligible indirect compensation. Complete as many entries as needed (see instance)	ructi	ons).		
	(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation				
	/h/ Enter name and EIN or address of names who provided you die	مامما	ree en elicible indirect con		An
	(b) Enter name and EIN or address of person who provided you dis	CIOSL	res on eligible indirect con	ipensau	on
	•				
	(b) Enter name and EIN or address of person who provided you dis	closu	res on eligible indirect com	npensati	on
			•	-	
	(b) Enter name and EIN or address of person who provided you dis	closu	res on eligible indirect com	npensati	on

Schedule C (Form 5500) 2019	Page <b>2-</b>
(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
•	
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensation
(~) = 1.1.1 and = 1.1.2 and =	

	Schedule C (Form 550	00) 2019		Page <b>3 -</b>		
answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensatio
		•	(a) Enter name and EIN o	r address (see instructions)		
UNITED	HEALTH CARE I	NSURANCE CO.		36-2739571		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e)  Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give yo formula instead an amount or estimated amou
	NONE	831,569	Yes No 🗵	Yes No		Yes No [
				address (see instructions)		
	TON DENTAL		a, Enter hame and Env or	91-0621480		
(b)	(c)	(d)	(e)	(f)	(a)	(h)
(b) Service Code(s)	person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f)  Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you formula instead an amount or estimated amou
Service Code(s)	Relationship to employer, employee organization, or person known to be	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan	Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	Did the service provider give yo formula instead an amount or estimated amou
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)  Yes No X	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	Did the service provider give you formula instead an amount or estimated amou
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)  Yes No X  A) Enter name and EIN or	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?  Yes No	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	Did the service provider give you formula instead an amount or estimated amount of the control o
Service Code(s)  12  CONNECT	Relationship to employer, employee organization, or person known to be a party-in-interest  NONE  ICUT GENERAL I	Enter direct compensation paid by the plan. If none, enter -0  269,313  (a)	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)  Yes No X  a) Enter name and EIN or E	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?  Yes No address (see instructions)  06-0303370	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you formula instead an amount of estimated amount of the service o
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest  NONE  (C)  Relationship to employee, employee	Enter direct compensation paid by the plan. If none, enter -0  269,313  (a)  LIFE INSURANC  (d) Enter direct compensation paid	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)  Yes No X  A) Enter name and EIN or E	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?  Yes No address (see instructions)  06-0303370	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0  (g)  Enter total indirect compensation received by service provider excluding eligible indirect	Did the service provider give you formula instead an amount or estimated amount.  Yes No No Children N
Service Code(s)  12  CONNECT  (b)  Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest  NONE  (c)  Relationship to employer, employee organization, or person known to be	Enter direct compensation paid by the plan. If none, enter -0  269,313  (a)  LIFE INSURANC  (d) Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)  Yes No X  a) Enter name and EIN or E  (e) Did service provider receive indirect compensation? (sources other than plan or plan	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?  Yes No  address (see instructions)  06-0303370  (f)  Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0  Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element	Did the servic provider give yo formula instead an amount or estimated amou

Schedule C (Form 5500) 2019			Page <b>4 -</b>			
answere	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in	total compensation
			(a) Enter name and EIN o	r address (see instructions)		
DAVIS W	RIGHT TREMAIN	Е		91-0839480		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h)  Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	148,778	Yes No 🛚	Yes No		Yes No
ć.		(	a) Enter name and EIN or	address (see instructions)	11	
		-				
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	74,998	Yes No 🗵	Yes No		Yes No
				address (see instructions)		<u> </u>
MOSS AD	AMS LLP	,	wy Enter Hame and EIN OF	91-0189318		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f)  Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?

Yes No

Yes No No

Yes 📗 No 🛚

22,500

NONE

	Schedule C (Form 55	00) 2019		Page <b>4 -</b>		
answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in	total compensation
		(	(a) Enter name and EIN o	r address (see instructions)		
CONEXIS				20-0198855		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	22,009	Yes No 🗓	Yes No No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
EXPRESS	SCRIPTS			41-1627938		
(b) Service Code(s)	Relationship to employer, employer, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	NONE	16,318	Yes No 🗓	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
SPECTERA	A		,	36-2739571		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?

Yes No

Yes No No

Yes No X

7,325

12

NONE

Schedule C (Form 5500) 2019	Page <b>5 -</b>		
Part I Service Provider Information (continued)			
3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect or provides contract administrator, consulting, custodial, investment advisory, investment questions for (a) each source from whom the service provider received \$1,000 or mor provider gave you a formula used to determine the indirect compensation instead of a many entries as needed to report the required information for each source.	ent management, broker, o in indirect compensation	or recordkeeping and (b) each sou	services, answer the following urce for whom the service
(a) Enter service provider name as it appears on line 2		rvice Codes structions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula us	ed to determine t	ompensation, including any the service provider's eligibility ne indirect compensation.
(a) Enter service provider name as it appears on line 2		vice Codes structions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula us	ed to determine t	ompensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2		vice Codes structions)	(c) Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation

(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to	Provide Infori	mation
4 Provide, to the extent possible, the following information for ea this Schedule.	ch service provide	er who failed or refused to provide the information necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Page 7	7 -
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_		
Pa	art III Termination Information on Accountants and (complete as many entries as needed)	l Enrolled Actuaries (see instructions)
a	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ēx	xplanation:	
a	Name:	<b>b</b> EIN:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	·
а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ex	planation:	
_	Negori	b ein:
a C	Name: Position:	D EIN.
d	Address:	e Telephone:
u	Address.	С текерпопе.
Ex	planation:	
а	Name:	<b>b</b> EIN:
C	Position:	
d	Address:	e Telephone:
Ex	planation:	<u> </u>

# SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

A Name of plan

For calendar plan year 2019 or fiscal plan year beginning

**Financial Information** 

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

and ending

Three-digit

01/01/2019

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

12/31/2019

HANFORD EMPLOYEE WELFARE TRUST			plan number (PN)				
C 20		D. 5. 11. 11. 11. 11. 11. 12. 12.					
C Plan sponsor's name as shown on line 2a of Form 5500			D Employer Identification Number (EIN)				
HEWT ADMINISTRATIVE COMMITTEE			91-2017261				
Part I Asset and Liability Statement							
1 Current value of plan assets and liabilities at the beginning and end of the the value of the plan's interest in a commingled fund containing the assets lines 1c(9) through 1c(14). Do not enter the value of that portion of an insu- benefit at a future date. Round off amounts to the nearest dollar. MTIA and 1i. CCTs, PSAs, and 103-12 iEs also do not complete lines 1d and 1e	of more than one rance contract whi s, CCTs, PSAs, ar	plan on a lin ich guarante nd 103-12 lE	e-by-line basis unless es, during this plan ye	the value is repar, to pay a spe	oortable on ecific dollar		
Assets		(a) Beg	inning of Year	(b) End	of Year		
a Total noninterest-bearing cash	1a		0		9,222		
<b>b</b> Receivables (less allowance for doubtful accounts):							
(1) Employer contributions	1b(1)		826,062		6,572,157		
(2) Participant contributions	1b(2)						
(3) Other	1b(3)		159,066		4,281,119		
<b>c</b> General investments:							
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)						
(2) U.S. Government securities	1c(2)						
(3) Corporate debt instruments (other than employer securities):							
(A) Preferred	1c(3)(A)						
(B) All other	1c(3)(B)						
(4) Corporate stocks (other than employer securities):							
(A) Preferred	1c(4)(A)						
(B) Common	1c(4)(B)						
(5) Partnership/joint venture interests	1c(5)						
(6) Real estate (other than employer real property)							
(7) Loans (other than to participants)							
(8) Participant loans	1c(8)						
(9) Value of interest in common/collective trusts	1c(9)						
(10) Value of interest in pooled separate accounts	1c(10)						
(11) Value of interest in master trust investment accounts	1c(11)						
(12) Value of interest in 103-12 investment entities	1c(12)						
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)						
(14) Value of funds held in insurance company general account (unallocat contracts)	ed 1c(14)						

1c(15)

(15) Other.....

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e	31,723	32,314
f	Total assets (add all amounts in lines 1a through 1e)	1f	1,016,851	10,894,812
	Liabilities			*
g	Benefit claims payable	1g	999,512	1,078,619
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	17,339	9,816,193
k	Total liabilities (add all amounts in lines 1g through1j)	1k	1,016,851	10,894,812
	Net Assets			
1	Net assets (subtract line 1k from line 1f)	11	0	0

## Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
a Contributions	s:			
(1) Received	or receivable in cash from: (A) Employers	2a(1)(A)	76,438,502	
(B) Partio	cipants	2a(1)(B)	31,182,871	
(C) Othe	rs (including rollovers)	2a(1)(C)		
(2) Noncash o	contributions	2a(2)		
(3) Total cont	ributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		107,621,373
b Earnings on i	investments:			
(1) Interest:				
	est-bearing cash (including money market accounts and icates of deposit)	2b(1)(A)		
(B) U.S.	Government securities	2b(1)(B)		
(C) Corpo	orate debt instruments	2b(1)(C)		
(D) Loans	s (other than to participants)	2b(1)(D)		
(E) Partio	cipant loans	2b(1)(E)		
(F) Other	r	2b(1)(F)		
(G) Total	interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends:	(A) Preferred stock	2b(2)(A)		
(B) Comr	non stock	2b(2)(B)		
(C) Regis	stered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total	dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
(3) Rents		2b(3)		
(4) Net gain (I	oss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggre	egate carrying amount (see instructions)	2b(4)(B)		
(C) Subtr	act line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized a	appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	· · · · · · · · · · · · · · · · · · ·	2b(5)(B)		
	unrealized appreciation of assets. ines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amoun	t	(b	) Total	
(6) Net investment gain (loss) from common/collective trusts						
(7) Net investment gain (loss) from pooled separate accounts	2b(7)					
(8) Net investment gain (loss) from master trust investment accounts	2b(8)					
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)					
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)					
C Other income						
d Total income. Add all income amounts in column (b) and enter total	-				107,62	1,373
Expenses	)					
Benefit payment and payments to provide benefits:						
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	24,	354,699			
(2) To insurance carriers for the provision of benefits	2e(2)	81,	558,643			
(3) Other	2e(3)		3,689			
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)				105,91	7,031
f Corrective distributions (see instructions)	200					
g Certain deemed distributions of participant loans (see instructions)						
h Interest expense	2h					
i Administrative expenses: (1) Professional fees	2i(1)	1,	704,342			
(2) Contract administrator fees	2i(2)					
(3) Investment advisory and management fees	2i(3)					
(4) Other	D1(4)					
(5) Total administrative expenses. Add lines 2i(1) through (4)	01(8)				1,70	4,342
Total expenses. Add all expense amounts in column (b) and enter total			-		107,62	
Net Income and Reconciliation	100					
k Net income (loss). Subtract line 2j from line 2d	2k					0
Transfers of assets:						
(1) To this plan	21(1)					
(2) From this plan	21(2)					
Part III Assountant's Oninion						
Part III Accountant's Opinion  Complete lines 3a through 3c if the opinion of an independent qualified publ	ia accountant is at	tached to this Earn	SEOO Come	alata lina 2d id	on online	a io not
attached.	ic accountant is at	tached to this Form	r 5500. Comp	nete iirie ou ii	ан орино	1 15 1100
a The attached opinion of an independent qualified public accountant for this	olan is (see instruc	ctions):				
(1) X Unmodified (2) Qualified (3) Disclaimer (	4) Adverse					
<b>b</b> Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.	103-8 and/or 103-	12(d)?		Yes	X No	
C Enter the name and EIN of the accountant (or accounting firm) below:						
(1) Name: MOSS ADAMS		(2) EIN: 91-01	189318			
d The opinion of an independent qualified public accountant is <b>not attached</b> to (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be at		Form 5500 pursua	int to 29 CFR	2520.104-50	ı.	
Part IV Compliance Questions						
CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs of 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete lines 4j and 4l. MTIAs also do not complete lines 4j and 4l. MTIAs also do		es 4a, 4e, 4f, 4g, 4	h, 4k, 4m, 4n	, or 5.		
During the plan year:		Ye	s No	Am	ount	
Was there a failure to transmit to the plan any participant contributions will period described in 29 CFR 2510.3-102? Continue to answer "Yes" for an fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	y prior year failure		x			
b Were any loans by the plan or fixed income obligations due the plan in declose of the plan year or classified during the year as uncollectible? Disresecured by participant's account balance. (Attach Schedule G (Form 550) checked.)	fault as of the gard participant lo )) Part I if "Yes" is	ans	X			7.
UNCURCU.	***************************************	4b	1 1			

ses to which the plan was a party in default or classified during the year as (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)  y nonexempt transactions with any party-in-interest? (Do not include transactions are 4a. Attach Schedule G (Form 5500) Part III if "Yes" is  covered by a fidelity bond?  ave a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by nesty?  bold any assets whose current value was neither readily determinable on an arket nor set by an independent third party appraiser?  cecive any noncash contributions whose value was neither readily on an established market nor set by an independent third party appraiser?  ave assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and is for format requirements.)	. 4d . 4e . 4f . 4g	X	X X X X X	Am	<b>4</b> ,000,00
(Attach Schedule G (Form 5500) Part II if "Yes" is checked.)  ly nonexempt transactions with any party-in-interest? (Do not include transactions lee 4a. Attach Schedule G (Form 5500) Part III if "Yes" is  covered by a fidelity bond?  ave a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by mesty?  cold any assets whose current value was neither readily determinable on an arket nor set by an independent third party appraiser?  ceive any noncash contributions whose value was neither readily on an established market nor set by an independent third party appraiser?  ave assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and is for format requirements.)  transactions or series of transactions in excess of 5% of the current lessets? (Attach schedule of transactions if "Yes" is checked, and	4d 4e 4f 4g 4h	х	x x x		4,000,00
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ave a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by nesty?  old any assets whose current value was neither readily determinable on an arket nor set by an independent third party appraiser?  ceive any noncash contributions whose value was neither readily on an established market nor set by an independent third party appraiser?  ave assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and is for format requirements.)  transactions or series of transactions in excess of 5% of the current assets? (Attach schedule of transactions if "Yes" is checked, and	4f 4g 4h		x		
arket nor set by an independent third party appraiser?	4h		х		
on an established market nor set by an independent third party appraiser?	1 411				
s for format requirements.) transactions or series of transactions in excess of 5% of the current issets? (Attach schedule of transactions if "Yes" is checked, and			х		
ssets? (Attach schedule of transactions if "Yes" is checked, and					
s for format requirements.)	4j		х		
an assets either distributed to participants or beneficiaries, transferred to another nt under the control of the PBGC?			х		
ailed to provide any benefit when due under the plan?	41		Х		
ividual account plan, was there a blackout period? (See instructions and 29 CFR	4m		х		
wered "Yes," check the "Yes" box if you either provided the required notice or one of to providing the notice applied under 29 CFR 2520.101-3.	4n				
n to terminate the plan been adopted during the plan year or any prior plan year? Year amount of any plan assets that reverted to the employer this year	es X	No			
lan year, any assets or liabilities were transferred from this plan to another plan(s), idee instructions.)	entify t	ne plan(:	s) to which	assets or liab	oilities were
plan(s)			5b	(2) EIN(s)	<b>5b(3)</b> PN(s)
n	to providing the notice applied under 29 CFR 2520.101-3	to providing the notice applied under 29 CFR 2520.101-3	to providing the notice applied under 29 CFR 2520.101-3	to providing the notice applied under 29 CFR 2520.101-3	to providing the notice applied under 29 CFR 2520.101-3

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? [ If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year	Yes	No	 ot determined instructions.)

REPORT OF INDEPENDENT AUDITORS AND FINANCIAL STATEMENTS

HANFORD EMPLOYEE WELFARE BENEFIT PLAN

December 31, 2019 and 2018



# **Table of Contents**

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# **Report of Independent Auditors**

To the Trustees and Hanford Employee Welfare Committee for the Hanford Employee Welfare Benefit Plan

#### **Report on the Financial Statements**

We have audited the accompanying financial statements of the Hanford Employee Welfare Benefit Plan (the Plan), which comprise the statements of net assets available for benefits as of December 31, 2019 and 2018, and the related statement of changes in net assets available for benefits for the year ended December 31, 2019, and the related notes to the financial statements.

#### Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

#### Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

# Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of December 31, 2019 and 2018, and the changes in its financial status for the year ended December 31, 2019, in accordance with accounting principles generally accepted in the United States of America.

Seattle, Washington September 9, 2020

Moss adams LLP

# Hanford Employee Welfare Benefit Plan Statements of Net Assets Available for Benefits

	December 31,			1,
	20	019	Įs.	2018
ASSETS	9			
Cash	\$	9,222	\$	-
Contribution receivable				
Sponsors	6,	572,157		826,062
Rebate receivable		149,022		159,066
Prepaid insurance		32,314		31,723
Premium rate stabilization reserve	4,	132,097		
Total assets	10,	894,812		1,016,851
LIABILITIES				
Drafts payable		31,345		50,385
Accounts payable	:	248,640		192,492
Other liabilities	10,	614,827	):	773,974
Total liabilities	10,	894,812	(	1,016,851
NET ASSETS AVAILABLE FOR BENEFITS	\$		\$	

# Hanford Employee Welfare Benefit Plan Statement of Changes in Net Assets Available for Benefits

ADDITIONS TO NET ASSETS ATTRIBUTED TO	Year Ended December 31, 2019
Contributions	A 70,400,500
Sponsors	\$ 76,438,502
Participants	31,182,871
Total additions	107,621,373
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO Benefit expense	
Health care claims	20,916,473
Health care premiums	75,929,549
Life insurance premiums	2,719,621
Disability insurance claims	3,096,893
Disability insurance premiums	3,254,495
Administrative expenses	1,704,342
Total deductions	107,621,373
CHANGE IN NET ASSETS	-
NET ASSETS AVAILABLE FOR BENEFITS Beginning of year	<u> </u>
End of year	\$ -

#### Note 1 - Description of Plan

Formation of the Plan – The Hanford Employee Welfare Benefit Plan (the Plan), filed as Hanford Employee Welfare Trust, provides benefits to the eligible employees of Hanford Site Contractors. The Plan was established January 1, 2000, and is administered by the Board of Trustees (Trustees). Prior to January 1, 2000, the benefits offered through this Plan were administered by Fluor Hanford. All sponsoring employers are prime contractors or subcontractors for the Department of Energy (DOE) at the Hanford Site in Richland, Washington.

**General** – The following description is provided for general information purposes only. Participants should refer to the Plan documents for complete information regarding all of the Plan's definitions, benefits, eligibility, and other matters. The Plan is a health and welfare plan and is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Benefits – The Plan currently provides comprehensive health benefits, life insurance coverage, long-term and short-term disability benefits, dependent care flexible spending accounts, and medical flexible spending accounts for employees.

Health, disability, and life insurance benefits are provided as either fully insured or claims based. Fully insured programs are administered by Kaiser Permanente Options Health Care, CIGNA, and Willamette Dental, Inc. Claims based benefits are administered by UnitedHealthcare, CIGNA, Express Scripts, Inc., and Delta Dental of Washington. Annual open enrollments offer participants the opportunity to change their coverage elections.

The Plan provides COBRA and/or Displaced Worker Medical Benefits (DWMB), which are administered by WageWorks (formerly, Conexis), to participants.

**Eligibility** – Both full and part time (in excess of 20 hours a week) regular employees are eligible for benefits. Employees terminated due to a reduction in force are also eligible for some Plan benefits for a limited period of time under the DWMB provisions.

Plan sponsors – During the year ended December 31, 2019, Energy Northwest was removed as a Plan sponsor. As of December 31, 2019, the Plan Sponsors include CH2M HILL Plateau Remediation Company; Johnson Controls, Inc.; Wastren Advantage, Inc.; Washington River Protection Solutions, LLC; and Mission Support Alliance, LLC, and its subcontractors (Akima Hanford Services, LLC; Dade Moeller & Associates; and Westech International MSA, LLC).

A sponsor may withdraw from participation in the Plan by giving 30 days written notice of intent to the Trustees.

Benefit payments and insurance premiums – Certain health and life benefit options provided to participants are self-funded by the Plan and are the responsibility of the Plan Sponsors. As such, the Plan makes payment on these claims and these claims are reflected as health care claims benefit expense on the statement of changes in net assets available for benefits.

# Hanford Employee Welfare Benefit Plan

#### **Notes to Financial Statements**

#### Note 1 - Description of Plan (continued)

Alternatively, certain health options provided to participants are administered by outside insurance companies. The premiums paid for these options are paid by the Plan and are reflected as premium payments on the statement of changes in net assets available for benefits. Payment of the premiums transfers the risk of benefit payment to the insurance company.

**Contributions** – Employees contribute amounts as determined by the Plan. The Plan Sponsors contributions are calculated by applying an annual rate to their base payroll. The rate is determined annually as necessary to adequately fund the Plan.

Other – The Trustees have the right under the Plan to modify the benefits provided to active employees, and participants receiving COBRA and/or DWMB. The Trustees have the right to amend and/or modify the Plan subject to ERISA provisions.

#### Note 2 - Summary of Significant Accounting Policies

**Basis of accounting** – The financial statements of the Plan are prepared on the accrual basis of accounting.

Use of estimates – The preparation of the Plan's financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein and disclosure of contingent assets and liabilities. Actual results could differ from those estimates. Significant estimates include management's determination of the allocation of employer contributions, contributions and rebates receivable and administrative expenses between the Plan and the Hanford Retiree Welfare Benefit Plan (Retiree Plan). Allocations are based on overall costs incurred or specific costs such as claims or pharmacy benefits paid.

Risks and uncertainties – Plan Sponsors may from time to time engage in labor negotiations, the results of which may have a financial impact on the Plan. The actuarial present value of postemployment benefit obligations is based on certain assumptions pertaining to interest rates, medical cost trend rates, which are subject to change. Due to the changing nature of these assumptions and the uncertainties inherent in the assumption process, it is at least reasonably possible changes in these assumptions in the near term could have a material effect on the financial statements.

**Cash** – Pursuant to the contractor's agreement with the DOE, the Plan does not maintain investments in interest-bearing accounts. Therefore, Plan assets are maintained in a noninterest-bearing cash account. Sufficient cash proceeds are maintained within the accounts to fund the daily cash requirements of both the Plan and the Retiree Plan. The Plan maintains its cash in bank accounts in amounts that, at times, may exceed federally insured limits. The Plan has not experienced any losses in such accounts.

# Hanford Employee Welfare Benefit Plan Notes to Financial Statements

#### Note 2 – Summary of Significant Accounting Policies (continued)

The Plan funds certain claim payments via wire transfer to accounts used by benefit providers for such payments on a check-cleared basis. At December 31, 2019 and 2018, the Plan had not completed such wire transfers to cover outstanding payments, resulting in drafts payable in these accounts. These amounts have been reflected as drafts payable on the statements of net assets available for benefits.

**Contributions receivable** – Contributions receivable represents the amount owed by Plan Sponsors to fund health care costs incurred through the end of the calendar year.

Other liabilities – Other liabilities represents amounts owed to Plan participants for health care and dependent care flexible account claims at the end of the calendar year. Also included are amounts contributed by Plan Sponsors in excess of benefit costs incurred for the year and credits due to Plan Sponsors for rate stabilization reserves used, as applicable. These amounts are credited to Plan Sponsors and/or used to offset future Plan Sponsor contribution requirements. Participant prepaid medical premiums used to offset future participant premium contribution requirements are also included in other liabilities.

Benefit obligation – Benefits obligations have been recognized for medical claims and disability benefits. The obligation for medical claims is calculated by the insurer based on the estimated value of claims incurred but not reported. A postemployment benefit obligation has been recognized for health and welfare benefits for individuals currently on long-term disability. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to employee service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from participants. The obligations represent the amounts that are expected to be funded by contributions from the Company and from existing assets of the Plan.

**Premium rate stabilization reserve** – The Plan has a rate stabilization reserve with an insurance company, which can be used to offset renewal rates in the subsequent year. The rate stabilization reserve credit as of December 31, 2019 and 2018, which the Plan Sponsors have elected to use in the subsequent year was \$4,132,097 and \$0, respectively. The reserve is nonrefundable should the insurance contract terminate.

**Administrative expenses** – Some administrative and professional fees relating to the direct management of the Plan's assets and benefit payments are funded by the Plan on behalf of the sponsoring companies.

**Plan termination** – The Plan committee or management of the Plan Sponsors has not expressed any intent to discontinue its contributions. In the event such discontinuance results in the termination of the Plan, the net assets of the Plan would be available for the exclusive use of the participants, but the manner and timing of allocation is left to the discretion of the Trustees.

Claims incurred but not reported – Obligations for medical claims incurred but not reported as of December 31, 2019 and 2018, are estimated by the insurers (see Note 5).

# Hanford Employee Welfare Benefit Plan Notes to Financial Statements

#### Note 2 - Summary of Significant Accounting Policies (continued)

Subsequent events – Subsequent events are events or transactions that occur after the statement of net assets available for benefits date but before financial statements are available to be issued. The Plan recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of net assets available for benefits, including the estimates inherent in the process of preparing the financial statements. The Plan's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statement of net assets available for benefits but arose after the statement of net assets available for benefits date and before financial statements are available to be issued.

The Plan has evaluated subsequent events through September 9, 2020, which is the date the financial statements were available to be issued.

#### Note 3 - Tax Status

The Plan established under the Trust holds the Plan's assets and pays benefits in accordance with the Hanford Employee Welfare Trust Agreement. Although the Plan is a taxable entity under the Internal Revenue Code, the Pan administrator understands that the Plan had no taxable income during the years ended December 31, 2019 and 2018. Accordingly, no provision or liability for income taxes has been included in the financial statements.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

#### Note 4 - Related Party and Funding of Benefit Obligations

The DOE requires that funding for postemployment benefits be provided on a pay-as-you-go basis, and the contractor sponsors of the Plan have adopted this policy. Therefore, the Plan Sponsors fund the Plan on a pay-as-you go basis and are subsequently reimbursed for the costs through their separate contracts with the DOE. Additionally, Mission Support Alliance, LLC, provides funding to the Plan through a letter of credit arrangement with the DOE on behalf of all other Plan Sponsors to meet cash requirements. The Plan refunds Mission Support Alliance, LLC, for its contributions on behalf of other plan sponsors. As a participating employer, Mission Support Alliance, LLC is also responsible for funding Plan contributions for its own employees. As of December 31, 2019, there was a net amount due from Mission Support Alliance, LLC in the amount of \$6,572,156. As of December 31, 2018, there was a net amount due from Mission Support Alliance, LLC in the amount of \$163,234.

## Note 5 - Plan Benefit Obligations

The following table details the statements of Plan benefit obligations at December 31

	2019	2018
Amounts currently payable Claims payable, claims incurred but not reported, and premiums due to insurers	\$ 3,643,582	\$ 3,779,348
Postemployment benefit obligations Long-term disability benefits payable		
for inactive participants	25,545,000	20,751,000
Total benefit obligations	\$ 29,188,582	\$ 24,530,348

The following table details the statement of changes in Plan benefit obligations for the year ended December 31:

	2019
Amounts currently payable  Balance at beginning of the year	\$ 3,779,348
Change in claims reported and approved for payment	(135,766)
Balance at end of year	3,643,582
Postemployment benefit obligations, net of amounts currently payable	
Balance at beginning of the year	20,751,000
Change in benefits accumulated	897,000
Impact of Change in Discount Rate	955,000
Term Cost	5,734,000
Interest Cost	481,000
(Gain)/Loss	1,227,000
Projected Benefit Payments	(4,500,000)
Balance at end of year	25,545,000
Total benefit obligations at end of year	\$ 29,188,582

The following were significant assumptions used to determine the postemployment benefit obligation as of December 31, 2019 and 2018:

Discount rate: 2.60% at December 31 2019, and 3.76% at December 31, 2018.

## Note 5 – Plan Benefit Obligations (continued)

Assumed health care cost trend rates ranged from 6.48% in 2019 decreasing to 5.00% in 2028 at December 31, 2018. Assumed health care cost trend rates at December 31, 2019, are:

Year Ending December 31,	Trend Rate
2020	6.16%
2021	5.85%
2022	5.54%
2023	5.22%
2024	5.18%
2025	5.13%
2026	5.09%
2027	5.04%
2028	5.00%
2029	4.95%
2030	4.91%
2031	4.86%
2032	4.82%
2033	4.77%
2034	4.73%
2035	4.68%
2036	4.64%
2037	4.59%
2038	4.54%
2039	4.50%

#### Note 6 - Form 5500

The 2019 Form 5500 for the Hanford Employee Welfare Benefit Plan (filed as Hanford Employee Welfare Trust), which is filed with the Department of Labor, has several assets, liabilities, income, and expenses that differ from the amounts shown on the accompanying statement of changes in net assets available for benefits. These differences relate to classification only and have no effect upon net assets available for benefits.

